icircle Care

PROVIDER MANUAL

January 2020

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INTRODUCTION TO ICIRCLE CARE

iCircle Care is licensed by the New York State Department of Health (NYSDOH) to offer a Medicaid Managed Long-Term Care Plan. Our foundation was built by collaborating with leading community-based providers who believed the region deserved a higher level of quality, choice, and personalized care. Through a distinctly compassionate and friendly approach to service and care, iCircle Care empowers people to live independently in their homes as productive members of their communities.

Providers and prospective membership were involved in the planning and development of iCircle Care, which now services 30 Western and Central New York counties. Each geographic area has a regional approach to serving our Members. We offer enrollment, care management, and Medicaid specialists who provide direct clinical care and assistance locally, in your neighborhood. Our regional approach to care is just one way we live up to our tagline - Hometown Care, Centered on You.

iCircle is committed to helping those who are chronically ill or have a disability find and receive the best and most effective long-term care and treatment. As a local, community-based organization, we understand the special health needs of our membership. iCircle believes that Members and their families should have accessible and open lines of communication with the Managed Long Term Care (MTLC) Plan care team and leadership right in their own community.

iCircle does not outsource any of its Provider related services, and its Provider Relations and Claims teams are all located in-house at iCircle's headquarters in Webster, New York.

About this Manual

This manual is intended to orient iCircle Care providers to Plan-specific policies and procedures. In addition, there is detailed information how our experienced Care Managers work with our Members and Providers to facilitate care, including information on the authorizations process, instructions on how to submit claims, and receive reimbursement for services rendered.

Service Area

iCircle operates in 30 counties throughout Western and Central New York, as well as the Southern Tier. Our service counties are listed below.

Allegany	Chenango	Livingston	Ontario	Steuben
Broome	Cortland	Madison	Orleans	Tioga
Cattaraugus	Delaware	Monroe	Oswego	Tompkins
Cayuga	Genesee	Niagara	Otsego	Wayne
Chautauqua	Erie	Oneida	Schuyler	Wyoming
Chemung	Herkimer	Onondaga	Seneca	Yates

How iCircle Works with Providers and Members

Provider Relations

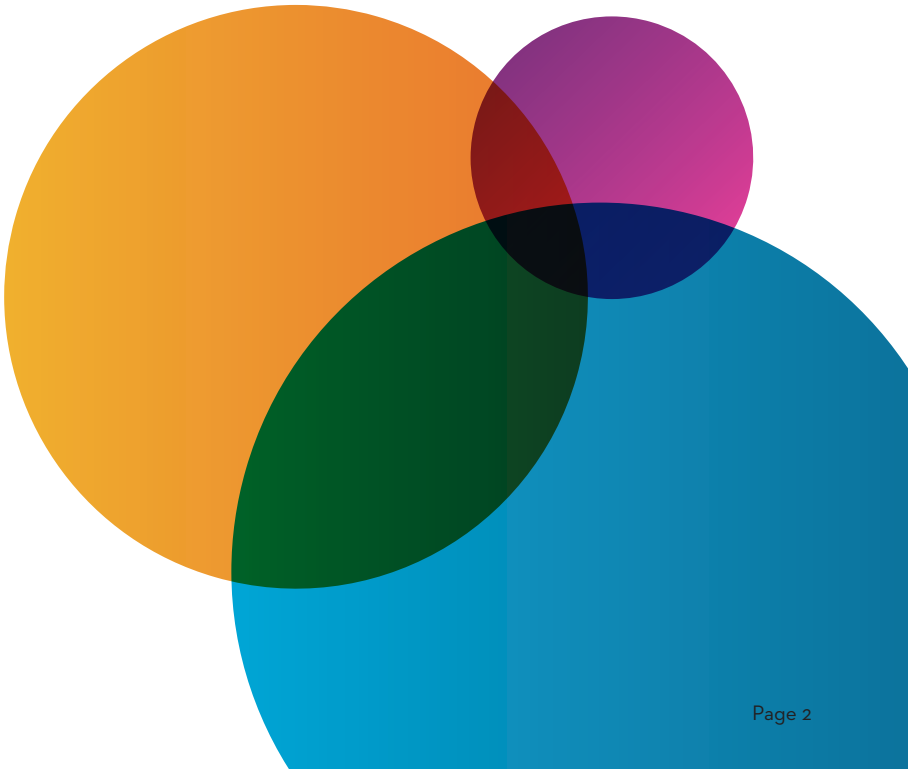
The Provider Relations Division is dedicated to fostering strong, long-term partnerships with all of iCircle's contracted Providers. This relationship begins with an initial orientation, as described below, and is followed by continuing education on policies, procedures, and any issues that concern Provider service delivery.

New Provider Orientation

The formal welcoming process, or Provider onboarding, will be conducted by your Provider Relations Representative within (30) days of contract execution. The onboarding will include an overview of iCircle and its processes and procedures, as well as information and education relating to billing and claims payment.

Change in Provider Data

Any change in a Provider's name, address, telephone number, ownership, Tax Identification Number, NPI, service area, or any other information should be reported to iCircle without delay. Please reach out to our Provider Services team to obtain and complete a demographic change form. You may also find the form on our website.



CARE MANAGEMENT/CLINICAL DEPARTMENT

Role of Care Manager

Upon joining the iCircle Care plan, all Members will be assigned an RN Care Manager who will provide case management services including care coordination. These services include:

- Development of a Person-Centered Service Plan (PCSP)
- Care management of covered services and coordination of non-covered services and other services provided by community resources and informal supports
- Development of a "back-up plan" to ensure continuation of services in the event that regular services in the PCSP are temporarily unavailable.
- Regular periodic assessment and reevaluation of service needs
- Communication with Member, family, and informal supports to develop health care goals, supports needed, and types and duration of authorized services required
- Provision of referrals and authorization of covered services
- Provision of discharge planning support and participation in the coordination of Members transitioning between settings such as hospital to nursing home or nursing home to home
- Availability to the Member, or provision of coverage by another Care Manager if necessary, twenty four (24) hours a day, seven (7) days a week to assist Member with urgent care or other issues.

Member Services Department

Member Services responds to Members' questions or concerns regarding their health care coverage. This includes information regarding covered benefits, choosing or changing a provider, orienting Members to our Plan, authorizing and arranging non-emergent transportation services, and providing other assistance. Member Services also solicits feedback from Members as to their satisfaction with the services provided by iCircle. We aim to address Member concerns or complaints quickly and efficiently.

Enrollment Department

iCircle's Enrollment Department processes Member referrals from Providers, and assists prospective Members with enrolling in an iCircle Plan. In the event that you would like to refer a client or patient to iCircle, you can contact our Enrollment team by calling 844-424-7253 or faxing a Pre-Enrollment referral form to 888-519-2816. Enrollment Coordinators are available Monday through Friday from 8:45am to 5:00pm. The Pre-Enrollment referral form can be found on iCircle's website (icirclecarecny.org).

MEMBER RIGHTS AND RESPONSIBILITIES

All managed care enrollees are guaranteed rights under Article 44 of the Public Health Law; all contracted MLTC Plans and contracted Providers are expected to comply with the rights of Plan Members.

Member Rights

- The right to receive medically necessary care.
- The right to timely access to care and services.
- The right to be provided with reasonable accommodation for Members with disabilities.
- The right to privacy about their medical record and when treatment is received.
- The right to get information on available treatment options and alternatives presented in a manner and language the Member/family/guardian understands.

• The right to get information, including all enrollment notices, informational materials, and instructional materials, in a language, manner, and format the Member and his or her family/caregiver understand. A Member can be provided with oral translation services free of charge.

• The right to be free from any form of discrimination on the basis of race, ethnicity, color, national origin, gender, disability, political beliefs, religion, sexual orientation, age, medical condition (including physical and mental illness), claims experience, receipt of health care, medical history, genetic information, or evidence of insurability or disability.

• The right to be free from abuse and neglect.

• The right to be treated with respect and dignity.

• The right to get information necessary to give informed consent before the start of treatment.

• The right to obtain a copy of their health records and ask that the records be amended or corrected.

• The right to take part in decisions about their health care, including the right to refuse treatment.

• The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

• The right to get care without regard to sex, race, health status, color, age, national origin, sexual orientation, marital status, or religion.

• The right to be told where, when, and how to get needed services including how to get covered benefits from out-of-network providers if they are not available in the network.

• The right to complain to New York State Department of Health or the Local Department of Social Services and the right to use the New York State Fair Hearing System and/or a New York State external appeal, where appropriate.

• The right to appoint someone to speak for them about Member care and treatment.

• The freedom to exercise all Member rights without any adverse effect on the Member's treatment by the Plan or our participating Providers.

In the event we are made aware of a Member being denied any of the rights identified above, we will initiate an investigation into the matter and report the findings to the appropriate department or agency.

Member Responsibilities

• To supply information (to the extent possible) that iCircle Care and its Care Managers and contracted Providers need in order to provide care.

• Follow care plans and instructions for care that the Member has agreed to with his or her Care Manager and Providers.

• Understand his or her health problems and participate in developing mutually agreed upon treatment goals, to the extent possible.

PROVIDER'S ROLE AND RESPONSIBILITIES

1. Providers shall provide services that conform to accepted practice standards in their communities. These community standards include, as appropriate, the rules of ethics and conduct as established by medical societies and other such bodies, formal and informal, governmental or otherwise, from which physicians seek advice or guidance or to which they are subject for licensing and control.

2. Provider shall immediately notify iCircle Care, in writing, if any of the following events occur:

- Provider's ability to provide the services for which it is contracted is restricted or impaired in any way;
- Provider's license required to practice their respective profession is limited, revoked, restricted, or suspended;
- Any adverse action is taken against the Provider;
- An investigation is initiated by any authorized local, State, or federal agency; or
- Provider is subject to any new or pending malpractice actions.

3. Providers shall comply with all iCircle Care administrative, Member referral, quality assurance, utilization management, and reimbursement policies and procedures.

4. Providers shall not differentiate or discriminate in the treatment of Members on the basis of race, sex, color, age, religion, marital status, veteran status, sexual orientation, national origin, disability, place of residence, health status, source of payment, or any other category protected by law, and shall observe, protect, and promote the rights of Members.

5. Providers shall cooperate and participate in all iCircle Care peer review procedures, including quality assurance, utilization review, grievance, and other processes as established by iCircle.

6. Providers will comply with all final determinations rendered by iCircle Care reviews or external third party reviewers for grievance procedures, consistent with iCircle policies and this Provider Manual.

7. Providers shall notify iCircle in writing of any change in office address, telephone number, office hours, or any other demographic change without delay.

8. Providers will not, under any circumstances, including non-payment by or insolvency of iCircle Care, bill, seek, or accept payment from Members for covered services with the exception of any applicable copayments or coinsurance.

9. Providers may freely communicate with Members about all available or viable treatment options, regardless of benefit coverage limitations.

10. Providers agree to maintain acceptable standards for documentation of medical records and confidentiality of medical records in accordance with all applicable State and federal laws, rules, and regulations.

a. Providers agree to retain medical records for six (6) years for all iCircle Care Members after the last date of service, or for the length of time dictated by applicable law.

11. Providers will maintain appointment availability and after hours emergency availability in accordance with applicable laws, rules, and regulations.

Fraud, Waste & Abuse (Medicaid Program Integrity)

Provider agrees to comply with the following as required by §6032 of the Federal Deficit Reduction Act of 2005:

- The False Claims Act;
- The penalties for submitted false claims and statement;
- Whistleblower protections; and
- The law's role in preventing and detecting fraud, waste and abuse, and each person's responsibility relating to detection and prevention.

For reference, please see the State's Medicaid Provider Manual and/or the New York State's Office of the Medicaid Inspector General website at www.omig.ny.gov/data/
OMIG audits and investigates providers suspected of overbilling and/or otherwise defrauding New York's Medicaid program, recovers overpayments, issues administrative sanctions, and refers cases of suspected fraud for criminal investigation.

To report suspected fraud and/or abuse in New York Medicaid:

Toll Free Hotline: 877-87-FRAUD (877-873-7283)

Online: www.omig.ny.gov

Email: bmfa@omig.ny.gov

Telephone: (518) 402-1378

Advance Directives

All Providers are required to comply with the Patient Self Determination Act of 1990 and any State, federal laws, rules, or regulations associated with Advance Directives.

Members can utilize an Advance Directive to provide instructions on his or her medical care should the Member be unable to communicate or make decisions about treatment. In addition Members can appoint a Health Care Proxy to make health care decisions for them if they are unable to do so.

HIPAA and Confidentiality Standards

The task of handling Member records and any other Protected Health Information (PHI) must be performed in compliance with the Health Insurance Portability and Accountability Act (HIPAA).
Provider acknowledges and agrees as follows:

- Member files will be kept confidential at all times;
- It may share PHI with iCircle only as it relates to treatment, payment, or health care operations;
- Email should not be used to transfer files with Member information unless it is encrypted;
- Fax machines should be positioned for privacy;
- Fax numbers should be confirmed before sending info to iCircle; and
- Voice mail messages should be restricted to least amount of information required.

All parties will comply with any applicable State and local privacy laws or regulations, including but not limited to §27-F of Public Health Law, §369 of the Social Services Law, and §33.13 of the Mental Hygiene Law.

Abuse, Neglect, and Exploitation Training

New York regulations dictate that all persons who examine, care for, or treat vulnerable adults have an affirmative duty to report suspected or confirmed elder abuse, neglect, or exploitation. Suspected elder abuse, neglect, or exploitation may be reported twenty four (24) hours a day seven (7) days a week by calling 1-800-342-3009 (New York State Office of Temporary and Disability Assistance) or contacting your local county Department of Social Services Adult Protective Services. When reporting suspected or confirmed abuse, neglect, or exploitation, please report the following information (if available):

- Each victim's name, age, sex, race, and physical description;
- Location of each victim alleged to have been abused, neglected, or exploited;
- Name, address and telephone number of the victims' family members, if possible;
- Name, address and telephone number of each alleged perpetrator;
- Name, address, and telephone number of the care giver, if this differs from the perpetrator;
- Name, address, and telephone number of the person reporting the abuse, neglect, or exploitation;
- Description of the physical or psychological injuries sustained;
- Actions you've taken, such as call the police, or family of the victim; and
- Any information you may have regarding the cause of the abuse, neglect or exploitation

iCircle is required to ensure that all direct care providers have knowledge of and attest they will maintain compliance with staff training relative to abuse, neglect, and exploitation.

It is your responsibility as the Provider to ensure that abuse, neglect, and exploitation training is conducted for employees that have contact with iCircle Members, and to maintain documentation of such training. You may be requested to make such documentation available to iCircle.

For additional information please refer to the New York State Office of Children and Family Services website at https://www.ocfs.state.ny.us/main/psa/

CREDENTIALING AND TERMINATION

Application Process

iCircle follows nationally recognized accreditation standards in the credentialing and re-credentialing of providers.

iCircle will make credentialing determinations within sixty (60) days of receipt of a complete credentialing application. The complete credentialing application includes but is not limited to the following:

- Current applicable State license
- Review of professional liability claims
- Review for Medicaid and Medicare sanctions
- Verification of good standing with CMS
- Proof of Professional Liability Insurance
- Appropriate and relevant accreditations and certificates

It is the policy of iCircle that information obtained in the credentialing process is kept confidential.

Provisional Credentialing

In the event that credentialing is delayed past sixty (60) days, iCircle Care may grant provisional credentialing to providers who have:

- appropriate licensing in good standing;
- a written application;
- verification of information from primary and secondary sources;
- confirmation of eligibility for payment under Medicare and/or Medicaid; and
- no adverse credentialing information.

Recredentialing

All providers must be recredentialed every three (3) years. iCircle Credentialing staff will reach out to the Providers to obtain updated applications and documentation as required. Providers will respond timely to any such requests, and in any event, will provide any required documentation within thirty (30) days. Failure to respond or to provide documentation may result in the termination of the Provider's contract.

Continuous Monitoring

In compliance with State and federal regulations, iCircle will perform exclusion checks against the excluded provider lists maintained by OIG and OMIG no less than every thirty (30) days. In the event that a Provider is verified as appearing on either such list, the Provider will be terminated from the iCircle network in compliance with applicable laws, rules, and regulations.

Provider Termination and Disciplinary Action

Provider Terminations and Disciplinary Action will occur in compliance with the requirements of §4406-d of the New York Public Health Law.

iCircle may choose to terminate your Participating Provider Agreement without cause upon ninety (90) days' written notice, or upon sixty (60) days' written notice in the event of a breach of contract. These timeframes shall not apply in cases involving imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board or other governmental agency that impairs the health care professional's ability to practice, in which case iCircle may terminate the contract immediately.

In the event of termination, if the Provider is an individual physician or provider, he or she may have the right to request a hearing or review before a panel appointed by iCircle, if such request is made within thirty (30) days of receipt of the termination notice.

- The hearing panel shall be comprised of three (3) persons appointed by the health care plan. At least one (1) person on such panel shall be a clinical peer in the same discipline and the same or similar specialty as the health care professional under review. The hearing panel may consist of more than three (3) persons, provided however that the number of clinical peers on such panel shall constitute one-third (1/3) or more of the total membership of the panel.

- The hearing panel shall render a decision on the proposed action in a professional by the health care plan, provisional reinstatement subject to conditions set forth by the health care plan or termination of the health care professional. Such decision shall be provided in writing to the health care professional.

- A decision by the hearing panel to terminate a health care professional shall be effective not less than thirty (30) days after the receipt by the health care professional of the hearing panel's decision.

SERVICE AUTHORIZATIONS

Prior Authorization

Prior authorization is a request by the Enrollee or Provider on Enrollee's behalf for a new service or a request to change a service as determined in the Plan of Care.

To request prior approval or authorization of a service, the Member or his or her doctor or provider may call the Plan. Services will be authorized in a certain amount and for a specific period of time. This is called the authorization period.

Most MLTC covered benefits and services require prior authorization. Prior authorization does not guarantee payment.

Timeframes for Prior and Service Authorization Requests

- Standard review: within three (3) business days of receipt of all necessary information, but no more than fourteen (14) days of receipt of request for services.

- Expedited review: three (3) business days from request for service.

Concurrent Review and Discharge Planning Requests

A Concurrent Review is a request by an Enrollee or Provider on Enrollee's behalf for additional services than are currently authorized in the Plan of Care; for example, Medicaid covered home health care services following an inpatient admission.

Review Process

Any request for additional services as described in this section will be reviewed by a qualified health care professional. If iCircle Care decides that the requested service is not medically necessary, the final decision will be made by a clinical peer reviewer, who may be a doctor, a nurse, or a health care professional who typically provides the care requested. Members can request the specific medical standards, called clinical review criteria, used. iCircle Services will tell the Member and his or her provider in writing if his or her request is approved or denied. The Member will also be informed of the reason for the decision.

The Member will be informed what options he or she has for appeals or fair hearings if he or she doesn't agree with our decision.

Timeframes for Concurrent Review Requests

After iCircle Services receives the request, the Plan will review it under a standard or expedited process. A Member or his or her doctor may ask for an expedited review if it is believed that a delay will cause serious harm to a Member's health. If the Member's request for an expedited review is denied, the Plan will inform them, and the request will be handled under the standard review process. In all cases, it will be reviewed as fast as the Member's medical condition requires.

- Standard review: Within one (1) business day of receipt of necessary information, but no more than fourteen (14) days of receipt of request for services.

- Expedited review: within one (1) business day of receipt of necessary information, but no more than three (3) business days of receipt of request for services.

- In the case of a request for Medicaid covered home health care services following an inpatient admission, one (1) business day after receipt of necessary information; except when the day subsequent to the request for services falls on a weekend or holiday, seventy-two (72) hours after receipt of necessary information; but in any event, no more than three (3) business days after receipt of the request for services. If the Plan needs more information to make either a standard or expedited decision about the Member's service request, the timeframes above can be extended up to fourteen (14) calendar days. The Plan will:

- Write and inform the Member what information is needed. If the request is an expedited review, the Plan will call the Member immediately and send a written notice later.

- Tell the Member why the delay is in his or her best interest.

- Make a decision as quickly as it can when the Plan receives the necessary information, but no later than fourteen (14) calendar days from the end of the original timeframe.

The Member, his or her representative, or the Provider, may also ask the Plan to take more time to make a decision. This may be because the Member has more information to give the Plan to help decide the Member's case. This can be done by calling the Member's assigned Care Manager. The Member or his or her representative can also file a complaint with iCircle Care if he or she does not agree with the Plan's decision, or file a complaint about the review time with NYSDOH by calling 1-866-712-7197.

Retrospective Review

Sometimes the Plan will do a concurrent review on the care a Member is receiving to see if he or she still needs the care. The Plan may also review other treatments and services the Member has already received. This is called a retrospective review. In this process, the Plan will inform the Member if it takes any of these following actions.

- Reduction, suspension, or termination of services. In most cases, if the Plan makes a decision to reduce, suspend or terminate a service it has already approved and which the Member is now receiving within an authorization period, the Plan must inform the Member at least ten (10) calendar days before it changes the service.

- Denial. If the Plan is reviewing care that has been given in the past, the Plan will make a decision about paying for it within thirty (30) calendar days of receiving necessary information for the retrospective review. If Plan denies payment for a service, the Plan will send a notice to the Member

and the Provider within three (3) business days of the denial decision. Members will not have to pay for any care he or she received that was covered by the MLTC Plan or by Medicaid even if the Plan later denies payment to the Provider.

Services That Require Physician Authorization

For some Covered Services, a Member may need a physician's order in addition to prior authorization. The Care Manager is available to assist Members with obtaining these medically necessary services and will help coordinate with the ordering physician.

Outpatient Physical (PT), Occupational (OT), Speech (ST) or Other Therapies

These services will be provided in an outpatient setting by a licensed professional. Medicaid coverage of outpatient PT, OT and ST provided in a setting other than a home is limited to 40 visits per calendar year for PT and 20 visits per calendar year for other therapies, except for children under age 21 and the developmentally disabled. The Plan may authorize additional visits.

Consumer Directed Personal Assistance Service (CDPAS)

Personal care services provided by a caregiver/personal assistant chosen and directed by the Member; includes assistance with such activities as personal hygiene, dressing, nutrition, and medication assistance. The caregiver is registered through a fiscal intermediary with which iCircle has an administrative agreement.

Respiratory Therapy (RT) Services

These services provided by a licensed respiratory therapist include but are not limited to instruction in the use of nebulizers and oxygen.

Durable Medical Equipment

iCircle Services will authorize all necessary equipment, supplies, and appliances for Members, such as: canes, walkers, wheelchairs, commodes, oxygen and respiratory equipment, wound care supplies, colostomy and diabetic supplies, enteral and parenteral nutrition and supplies, artificial limbs, braces, and shoe inserts or orthopedic shoes. Applicable service limitations can be discussed with the Member's Care Manager.

Medical Social Services

A licensed social worker will assess a Member's need for, and arrange for the provision of, aid to assist Members in dealing with social and environmental difficulties and maintaining the Member's home.

Nursing Home Care

Nursing home care for short-term rehabilitative stays, which occur mainly after hospitalizations, are covered by the Plan. However, an admission to a nursing home for a long-term care may occur when staying at home is no longer safe. These services require a physician's order and prior authorization by the Plan.

Authorization Revisions

In an effort to streamline our service delivery, we have established a process with regard to Provider requests for revised authorizations.

When a Provider receives an authorization, it is important to confirm accuracy immediately. It is the Provider's responsibility to review all authorizations for completeness and appropriateness as outlined in the guidelines maintained by the New York State Department of Health at www.emedny.org. If a revision is needed the Provider can request it from the Care Manager directly only if the authorization was issued fewer than thirty (30) days prior to the request. For revisions to authorizations issued more than thirty (30) days from the request, the Provider must complete the Authorization Revision Form, found on the iCircle website, and submit it by email to AuthRevisionRequest@icirclecny.org. The Provider can expect a response within five (5) business days of the submitted request.

By working together and communicating efficiently we can be assured that Provider requests are being reviewed by the appropriate clinician and that our Members receive needed services in a timely manner.

COMPLAINTS AND APPEALS

You may contact iCircle to file a complaint or initiate an appeal by calling 855-775-3778, by fax at 888-519-2816, or by U.S. mail to iCircle Care, 860 Hard Road, Webster, New York 14580.

Appeals

This section describes two types of Provider denials: (A) denials for lack of medical necessity, and (B) administrative denials. If Providers disagree with a denial made by iCircle due to lack of medical necessity or an administrative denial, Providers will follow the process set forth in this section.

A. Denial for Lack of Medical Necessity

iCircle will not reimburse for services or equipment that are not medically necessary. Decisions regarding medical necessity are made by iCircle's Chief Medical Officer or Medical Director through the Medical Review process. Providers, Members, or the Member's representative may appeal iCircle's determination regarding medical necessity through the process described below.

Appealing a Determination Based on Medical Necessity

Standard Appeals

If iCircle Care denies a request for services or equipment based on a lack of medical necessity, a Provider, Member, or Member's representative may appeal the decision within sixty (60) business days of receipt of the denial. The Provider and Member will receive written determination from iCircle with instructions on how to file an appeal. An appeal is initiated by contacting iCircle either by telephone or via US mail using the contact information at the beginning of this section. Verbal requests for appeals must be followed up with a written request. iCircle requests that all appeals include the following documentation: the Member's medical records concerning the service or equipment at issue, a summary of the need for the service or equipment as prepared by the Provider, and a copy of the original denial letter. If the original letter is not available, the appeal should indicate the dates of service at issue, the Member's name, and the iCircle Care Member ID number.

iCircle will acknowledge the initiation of the appeal within fourteen (14) calendar days after receiving the appeal.

iCircle must make a standard appeal determination as fast as the Member's condition requires, and in any event, no later than thirty (30) calendar days from the receipt of the appeal. This time may be extended for up to fourteen (14) days upon Member or Provider request, or if iCircle determines that additional information is needed, and an extension of time is in the best interest of the Member. If the timeframe is extended, iCircle will notify the Member accordingly.

iCircle's written determination regarding the appeal will be mailed to the Member, the Member's representative if applicable, and the Provider within two (2) business days of the determination. iCircle will indicate the reason(s) for its decision and, if the appeal is denied and the original determination upheld, the clinical rationale for upholding the clinical denial. This written notice of determination includes a notice of the Member's right to an external appeal and a description of the external appeal process, if applicable, as well as the Member's right to request a fair hearing through New York State.

Each notice of the final adverse determination will be in writing and will include:

1. A summary of the appeal and date filed.

2. The date of the decision.

3. The basis and clinical rationale for the determination.

4. The name and phone number of the contact person at iCircle.

5. The service that was denied, including the facility/provider, manufacturer, etc.

6. A statement outlining the Member's fair hearing rights.

7. A statement of the Member's right to complain to NYSDOH at any time, and the contact information to do so.

8. A statement that the notice is available in other languages and formats for special needs, as well as an explanation on how to access these formats.

Standard appeals will be conducted by a clinical peer reviewer, provided that any such appeal will be reviewed by a clinician other than the clinician who rendered the initial adverse determination. If the appeal determination is adverse, and the initial denial is upheld, it is considered a final adverse determination.

Expedited Appeals
A Provider, Member, or Member's representative may seek an expedited appeal in the event of the following:

• If iCircle determines that continued or extended health care services that are prescribed by a health care provider and are currently being received are not medically necessary;

• If the Provider believes an immediate appeal is necessary, provided that the initial determination regarding a lack of medical necessity was not retrospective.

If iCircle agreed to review the appeal on an expedited basis, it will render a decision as fast as the Member's condition requires, and within two (2) business days of receipt of all necessary information. This time may be extended for up to fourteen (14) days upon Member or Provider request, or if iCircle determines that additional information is needed, and an extension of time is in the best interest of the Member. If the timeframe is extended, iCircle will notify the Member accordingly.

iCircle will make all reasonable efforts to provide verbal notice to the Member and Provider at the time the determination was made; however, in any event, notice of iCircle's final determination regarding an expedited appeal will be transmitted to the Member and Provider within twenty-four (24) hours of iCircle rendering its decision. The notice will include the description of the member's right to pursue an external appeal if they so choose.

External Appeals
Pursuant to Article 49 of the New York State Public Health Law, an external appeal process is available through the State Department of Financial Services. The time period to file an external appeal is within four (4) months from the receipt of the final adverse determination of the first level appeal. Providers acting on their own behalf must file external appeals within sixty (60) calendar days. The external appeal decision will be rendered in thirty (30) calendar days for a standard review, and two (2) business days for an expedited review. External decisions are final, and are not subject to arbitration or further review by a court of law.

An external appeal may be requested in the following ways:

- Calling the Department of Financial Services at 800-400-8882; or

- Going to the Department of Financial Services' website at www.dfs.ny.gov and downloading the external appeal application

Provider External Appeal Rights
A Provider will be responsible for the full cost of an appeal for a concurrent adverse determination upheld in favor of iCircle.

iCircle will be responsible for the full cost of an appeal for a concurrent adverse determination that is overturned.

iCircle and the Provider must evenly divide the cost of a concurrent adverse determination that is overturned in part.

Fair Hearings
In some cases, Members may ask for a fair hearing from New York State. A Member may request a fair hearing with regard to 1) the denial, suspension, termination, or reduction or services covered under the Plan benefit package; or 2) a belief that iCircle did not act in a timely manner with regard to authorizing services. A Member may have any individual he or she selects or designates to represent them at a fair hearing.

If a Member is receiving services that are scheduled to end, he or she may request a continuation of those services while his or her fair hearing is pending. However, if the fair hearing determination is not in the Member's favor, the Member may have to pay for these services if they were provided only at the Member's request while the appeal was being reviewed.

The administrative law judge's determination will be final.

A Provider does not have standing to request a fair hearing on his or her own behalf. However, a Provider may assist a Member in requesting a fair hearing from New York State.

B. Administrative Appeals
An administrative denial is defined as a denied request for authorization of services that is not based on medical necessity, as well as claim payment denial. Examples include denials based on timely submission of a claim, Member eligibility, or the absence of a required authorization.

Authorization Appeals

If iCircle denies a request for authorization of services and the basis for the denial is not lack of medical necessity, the Provider, Member, or Member's representative may appeal the denial if they do not agree. Examples include a non-covered benefit, a benefit that has been exhausted, or an eligibility issue.

The appeal must be made within sixty (60) business days of the provider receiving the denial. The denial letters are sent to the Provider and Member, and contain instructions regarding requests for appeals.

An appeal is initiated by contacting iCircle either by telephone or via U.S. mail using the contact information at the beginning of this section. Verbal requests for appeals must be followed up with a written request. iCircle requests that all appeals include the following documentation: the Member's medical records concerning the service or equipment at issue, a summary of the need for the service or equipment as prepared by the Provider, and a copy of the original denial letter. If the

original letter is not available, the appeal should indicate the dates of service at issue, the Member's name, and the iCircle Care Member ID number.

iCircle will acknowledge the initiation of the appeal within fourteen (14) calendar days after receiving the appeal.

iCircle must make a standard appeal determination as fast as the Member's condition requires, and in any event, no later than thirty (30) calendar days from the receipt of the appeal. This time may be extended for up to fourteen (14) days upon Member or Provider request, or if iCircle determines that additional information is needed, and an extension of time is in the best interest of the Member. If the timeframe is extended, iCircle will notify the Member accordingly.

iCircle's written determination regarding the appeal will be mailed to the Member, the Member's representative if applicable, and the Provider within two (2) business days of the determination. iCircle will indicate the reason(s) for its decision and, if the appeal is denied and the original determination upheld, the clinical rationale for upholding the clinical denial. This written notice of determination includes a notice of the Member's right to request a fair hearing.

Each notice of the final adverse determination will be in writing and will include:

1. A summary of the appeal and date filed.

2. The date of the decision.

3. The basis and clinical rationale for the determination.

4. The name and phone number of the contact person at iCircle.

5. The service that was denied, including the facility/provider, manufacturer, etc.

6. A statement outlining the Member's fair hearing rights.

7. A statement of the Member's right to complain to NYSDOH at any time, and the contact information to do so.

8. A statement that the notice is available in other languages and formats for special needs, as well as an explanation on how to access these formats.

There is only one level of standard appeals on any internal decision. Following iCircle's final notice of determination, Members or their representatives may view the case file.

Expedited Authorization Appeals

A Provider, Member, or Member's representative may seek an expedited appeal if the Provider believes an immediate appeal is necessary.

If iCircle agrees to review the appeal on an expedited basis, it will render a decision as fast as the Member's condition requires, and within two (2) business days of receipt of all necessary information. This time may be extended for up to fourteen (14) days upon Member or Provider request, or if iCircle determines that additional information is needed, and an extension of time is in the best interest of the Member. If the

timeframe is extended, iCircle will notify the Member accordingly.

iCircle will make all reasonable efforts to provide verbal notice to the Member and Provider at the time the determination was made; however, in any event, notice of iCircle's final determination regarding an expedited appeal will be transmitted to the Member and Provider within twenty-four (24) hours of iCircle rendering its decision.

Claims Denials

Please submit claims appeals to Provider Service at providerservice@icirclecny.org, or by facsimile to 888-519-2816.

Denial of Payment

If a Provider disagrees with a claim denial, the Provider must attach documentation supporting payment along with a Claim Appeal Form, which can be found on iCircle's website, within ninety (90) days of the remittance advice for the claim. If a Provider does not submit the form within the required timeframe, iCircle's initial determination is final, and will not be subject to arbitration or review by any court of law.

Underpayments

If a provider disagrees with the claim payment amount, the provider shall attach documentation supporting additional payment, along with a Claim Appeal Form, which can be found on iCircle's website, within ninety (90) days of the remittance advice for the claim. If a Provider does not submit the form within the required timeframe, iCircle's initial determination is final, and will not be subject to arbitration or review by any court of law.

Overpayments

If a claim is overpaid, Providers should request an adjustment by submitting a Claim Appeal Form and a copy of the remittance advice that indicates the overpayment. If iCircle agrees with the request, the overpayment will be deducted from a future payment. The Provider should not return the check containing the overpayment.

If iCircle determines that an overpayment has been made, prior to engaging in recovery efforts, iCircle will provide the Provider with thirty (30) days' advance written notice as described in New York State Insurance Law §3224-b. Such notice will include the Member name, date(s) of service, payment amount, proposed adjustment, and a reasonable explanation supporting the recovery efforts.

Claim Denials for Invoice

iCircle may deny a claim where it requires a copy of the manufacturer's invoice for processing. Providers may send a copy of the invoice via facsimile at the number above, or via U.S. mail to:

iCircle Care
Attn: Claims
P.O. Box 1320
Webster, New York 14580

Please ensure you have included the Member's name, Member ID number, as well as the claim number associated with the invoice request. If iCircle does not receive this information within ninety (90) days of the date the claim was denied, the claim determination will be deemed final and without further recourse, and will not be subject to arbitration or review by a court of law.

Member Complaints

All iCircle Members have the right to file a complaint at any time if they are dissatisfied with iCircle, a Provider, or with the care or services they have received. iCircle makes every effort to address Member concerns or issues as quickly as possible to the Member's satisfaction. There will be no change in the Member's services or the way he or she is treated by the iCircle staff or a health care provider because he or she has filed a complaint.

Members are advised to contact Member Services to file a complaint. Complaints are submitted in writing or recorded by iCircle staff on behalf of Members. All complaints are logged and acknowledged by iCircle in writing.

Complaints relative to the delivery of health care services will be referred to iCircle's Quality and Compliance Department.

If the complaint involves a Provider, a Provider Relations Representative will contact the Provider to discuss the complaint. The findings will be reported back to the Quality and Compliance team for consideration as to action or disposition.

How to File a Complaint

If a Member has an issue or dispute regarding care of services, the Member may file a complaint with iCircle. iCircle is always available to assist a Member with filing a complaint, complaint appeal, or other appeal. A Member Service Associate can assist the Member or their representative with filing. If a Member needs assistance because of hearing or vision impairment, requires translation services, or needs help filling out forms, iCircle can assist.

To file by phone, the Member should call Member Services at the number found on the back of their Member ID card, Monday through Friday from 8:00am to 5:00pm. A Member can also file a complaint in writing.

If iCircle cannot solve the problem right away over the phone, or if iCircle receives a written complaint, an acknowledgement letter will be sent to the Member within fourteen (14) days.

Members may always file a complaint with NYSDOH by calling 866-712-7197 or writing to New York State Department of Health, Bureau of Managed Long Term Care, One Commerce Plaza, 16th Floor, Albany, New York 12210.

Member written complaints received will be responded to within forty five (45) business days of receipt of the complaint. When a delay would risk a Member's health or welfare, iCircle will make a determination within forty eight (48) hours of receipt of all necessary information, but no later than seven (7) days from the date of filing. iCircle will call the Member and send the Member a letter with the reason(s) for our decision. The complaint decision notice will also inform the Member of their appeal rights if the Member is not satisfied with iCircle's decision. If iCircle is unable to make a decision regarding a complaint because we need additional information, the Member will be notified by letter.

Complaint Appeals

If the Member is not satisfied with iCircle's determination, he or she can request a second review of the issue by filing a complaint appeal. A complaint appeal must be filed within sixty (60) business days of receipt of the initial determination. Once a complaint appeal is filed, iCircle will provide the Member with written acknowledgment of receipt.

The complaint appeal will be reviewed by the appropriate iCircle staff, and will not be reviewed by any individuals that were involved in making the initial determination.

For standard complaint appeals, the Plan will make a decision within thirty (30) business days after receipt of all required information and documentation. If a delay in making a determination on the complaint appeal would significantly increase risk to the Member's health or welfare, iCircle will employ the expedited complaint appeal process, and will make a determination within two (2) business days of receipt of all required information and documentation. For both standard and expedited complaint appeals, the Plan will provide the Member with written notice of its decision. The notice will include the detailed reasons for its decision and, in cases involving clinical matters, the clinical rationale for the Plan's determination.

If a Member disagrees with iCircle's decision, he or she can file an appeal.

Transportation Guidelines

Non-Emergent Transportation by ambulance, ambulette, taxi, or livery service, as well as public transportation (where available) is a covered benefit to assist a Member in obtaining necessary medical care and services. In order to access this covered service the Member will need to make prior arrangements with Member Services at least three (3) business days, but no more than thirty (30) days, in advance of the appointment date. Member Services can also coordinate recurring transportation requests.

Emergency Services

Emergency services means medically necessary services required to evaluate and stabilize an emergency medical condition. MLTC Plans do not cover emergent transportation or emergency costs. An emergency medical condition means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in: (a) placing the health of the person affected with such condition in serious jeopardy, or in the case of a behavioral condition placing the health or such person or others in serious jeopardy; (b) serious impairment to such person's bodily functions; (c) serious dysfunction of any bodily organ or part of such person; or (d) serious disfigurement of such person.

If a Member has an emergency and needs immediate medical attention, they should call 911 or go to the nearest hospital emergency room. The Care Manager should be notified within 24 hours of the emergency. If the emergency results in a hospital admission, the Member (if possible), a family member, or other support should contact iCircle Care within 24 hours of the admission. The Care Manager will then cancel any scheduled services or appointments that the Member may have. If the Member is in the hospital, the physician or discharge planner should be asked to contact iCircle. We will then work with them to plan for the Member's care upon discharge.

CLAIMS

Clean Claims

The provider shall routinely submit timely and clean claims. A "clean claim" is a claim that meets the requirements of 11 NYCRR Section 217.2 (if it is a paper claim), or the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), if it is an electronic claim, which is received timely by the Plan, and has no defect, impropriety, or lack of substantiating documentation from the Member's medical record regarding the Covered Services.

Claims Requiring Manufacturer's Invoice

Claims that require a manufacturer's invoice (e.g., miscellaneous DME) for payment consideration must be submitted with the following information/documentation in order to be validated as an acceptable invoice:

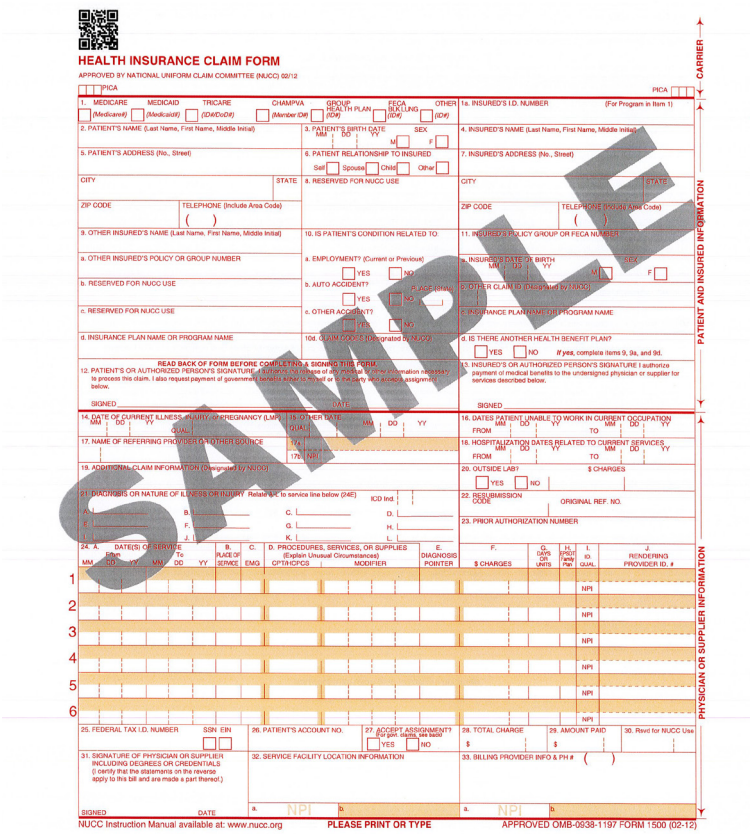
- Manufacturer's name
- Provider name
- Item with description
- Acquisition cost on the invoice
- Invoice date

Any claims received by iCircle that require an invoice and are missing either the invoice or the requirement elements described above will be denied.

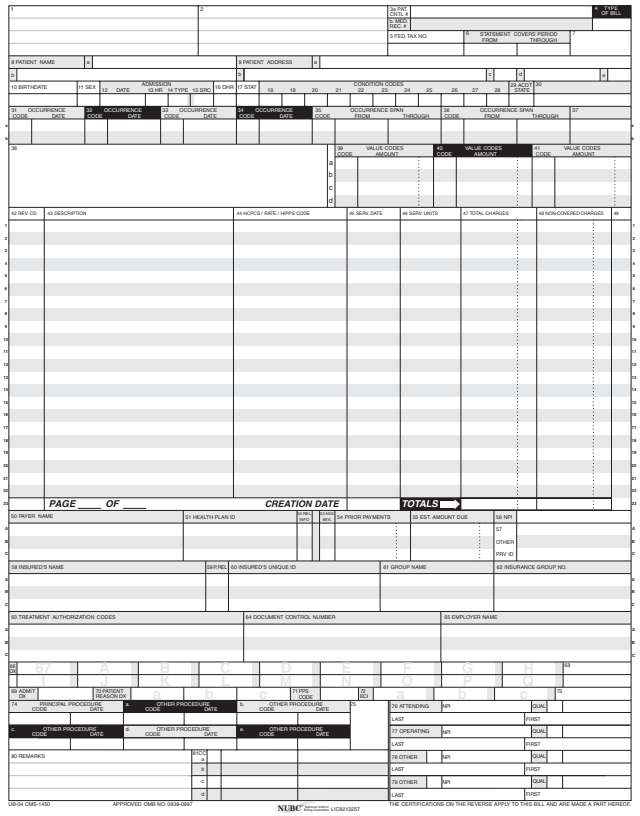
Paper Claims Forms

Before submitting a claim, a Provider should ascertain that all required attachments are included. All claims that involve other insurance must be accompanied by an Explanation of Benefits (EOB) or a remittance advice that clearly states how the claim was paid or the reason for denial.
Providers can submit hard copy claims directly to iCircle via US mail at:
iCircle Care
Attn: Claims
P.O. Box 1320
Webster, New York 14580
iCircle requires Providers to use one of the following forms when submitting paper claims:

• A CMS 1500 (formerly HCFA 1500) billing form is used to submit paper claims for professional services.



• Home health care, skilled nursing, and nursing home room and board must be billed on the UB-04 billing form.



Electronic Claims

To submit electronic claims to iCircle's clearing house, VisibilEDI, Providers will first need to obtain the required software.

The Provider will need to register with VisibilEDI or another clearing house. Once registered, the Provider will be able to submit electronic claims following the clearing house's instructions.

Providers will need to use the following payer ID when billing iCircle through a clearing house: ICRCL

Claims Resubmission

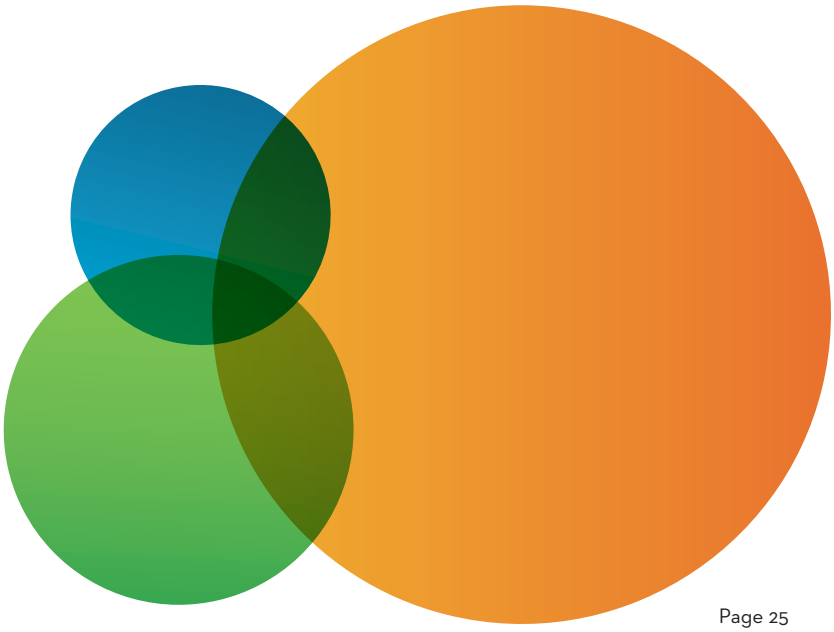
iCircle will consider a claim for resubmission only if it is rebilled in its entirety within 180 days of the date of service. The Provider must provide written explanation for the resubmission.

Claims Reconsideration

Providers have 180 days from the date of remittance to resubmit a claim, or the original payment will be considered full and final. When requesting a review of denial or payment the Provider believes to be incorrect, the Provider must include the following information:

- The reason the Provider believes the claim was incorrectly paid or denied;
- The Member's name, date of birth, and ID number;
- The service/admission date;
- The location of treatment or services;
- A copy of the claim;
- A copy of the remittance advice on which the claim was denied or incorrectly paid; and
- Any other documentation supporting the request.

Providers can check the status of claims by contacting the Provider Services team at 844-283-2884.



PROVIDER QUICK REFERENCE GUIDE

Contact Us

General Inquiries or Enrollment:
844-iCircle (424-7253)
TTY/TDD dial 711
info@icirclecarecny.org
Website: www.icirclecny.org

Prior Authorizations:
884-694-2273

Authorization Revision:
authrevisionreq@icirclecny.org

Member Services:
844-MY-iCare (694-2273)

Provider Service:
844-283-2884
provider.service@icirclecny.org
Hours of Operation:
M–F 8am–5pm

Contracting:
contracts@icirclecny.org

Member Complaints/Appeals:
Phone: 855-775-3778
Fax: 888-519-2816

Individual Staff Emails & Direct Phone Lines:
During the course of a provider or member inquiry, iCircle staff may provide you with direct contact information to expedite the request. Please note, that staff may change throughout time, and we always encourage providers and members to utilize the general group emails/phone lines outlined above to ensure your inquiry is responded to as efficiently as possible. It is against iCircle policy to give out our full staff contact list including direct email and direct phone lines for this purpose, and to prevent our staff from receiving unwarranted emails or calls that should be directed to a different department.

Claims Submission
CMS 1500 billing forms are used for billing professional services.

UB-04 billing forms are used for billing home health care, skilled nursing, and nursing home room and board.

Paper claims can be mailed to:
iCircle Care
Attn: Claims
P.O. Box 1320
Webster, New York 14580

Electronic claims, both professional and institutional, can be submitted via clearing house. iCircle's clearing house is VisibilEDI, and its payer ID is ICRCL.

Referrals
To make a referral to iCircle:
Call: 844-424-7253
Visit: www.icirclecarecny.org
Email: enrollment@icirclecarecny.org
Mail: 860 Hard Road, Webster, New York 14580

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